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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

AMERICANA HEALTHCARE CORPORATION; ELKHART AMERICANA, INC., d/b/a AMERICANA HEALTHCARE CENTER OF ELKHART; CAPITOL AMERICANA, INC., d/b/a AMERICANA HEALTHCARE CENTER OF INDIANAPOLIS—MIDTOWN,
Petitioners,

vs.

RICHARD SCHWEIKER, Secretary, Department of Health & Human Services,
Respondent.

TURTLE CREEK CONVALESCENT CENTERS, INC., d/b/a NORTHSIDE HEALTHCARE CENTER,
Petitioner,

vs.

RICHARD SCHWEIKER, Secretary, Department of Health & Human Services,
Respondent.

CARE INNS, INC., d/b/a CLARKSVILLE HEALTHCARE CENTER,
Petitioner,

vs.

ROBERT F. SMITH, Acting Administrator, DONALD L. BLINZINGER, Administrator, Indiana Department of Public Welfare,
Respondents.

(Continued Inside Front Cover)

CARE INNS, INC., d/b/a CLARKSVILLE HEALTHCARE CENTER,
Petitioner,

vs.

RICHARD SCHWEIKER, Secretary Department of Health & Human Services
Respondent.

LAURA HATHAWAY, d/b/a R.N. Nursing Home,
Petitioner,

vs.

RICHARD SCHWEIKER, Secretary Department of Health & Human Services,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTIONS PRESENTED

There are three questions presented to the United States Supreme Court by this case:

1. Did the United States District Courts have mandamus jurisdiction pursuant to 28 U.S.C. §1361 to order the Secretary of the Department of Health and Human Services, to comply with the recently enacted Omnibus Reconciliation Act of 1980, P.L. 96-499, to accord nursing care facilities evidentiary hearings prior to termination from the Medicare and Medicaid Programs.

2. Under the facts herein, did the Petitioners raise colorable constitutional claims sufficient to confer subject matter jurisdiction on District Courts pursuant to 42 U.S.C. §405(g).

3. Did District Courts have subject matter jurisdiction pursuant to 28 U.S.C. §1331(a), and did the District Court in No. 81-2873, Care Inns, properly exercise pendent jurisdiction over state defendants in litigation involving continued participation in the Medicaid Program.

PARTIES TO THE PROCEEDING

The parties to the proceedings in the courts below are listed in the caption to this Petition.[1] Additionally, Judy Carrothers was a plaintiff in the Laura Hathaway case, but is not a petitioner before this court.

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[1]Pursuant to Supreme Court Rule 28.1, Petitioners note that the parent corporation of Turtle Creek Convalescent Centers, Inc. and Care Inns, Inc. is ARA Healthcare Management, Inc. of Houston, Texas, which is a wholly owned subsidiary of ARA Services, Inc. Americana Healthcare Corporation is a wholly owned subsidiary of Manor Care, Inc.

TABLE OF CONTENTS

	Page
Questions Presented	i
Parties to the Proceeding	i
Table of Contents	ii
Table of Citations and Authorities	iii, iv
The Opinions Below	1
Jurisdiction	1
Constitutional Provisions Involved	1
Statutory Provisions Involved	2
Statement of the Case:	
A. Nature of the Case	2
B. The Statutory and Regulatory Framework	2
C. Statement of the Facts	7
D. Basis for Federal Jurisdiction in District Court	11
Argument:	
1. District Courts Clearly Had Mandamus Jurisdiction Pursuant to 28 U.S.C. §1361 in Order to Enforce Compliance by the Secretary of the Department of Health and Human Services with Certain Directives Contained in the Newly Enacted 42 U.S.C. §1395(cc)(f)	11
2. The District Courts Properly Exercised Subject Matter Jurisdiction in These Actions Pursuant to 42 U.S.C. §405(g)	17
3. The District Courts Properly Exercised Subject Matter Jurisdictions in These Actions Pursuant to 28 U.S.C. §1331(a)	22
Conclusion	25

TABLE OF CITATIONS AND AUTHORITIES

Cases	Page
Bell v. Woolfish, 441 U.S. 520 (1979)	14
Bracco v. Lackner, 462 F. Supp. 436, (D. Cal. 1978)	18, 19
Califano v. Sanders, 430 U.S. 99 (1976)	24
Case v. Weinberger, 523 F.2d 602 (2nd Cir. 1975)	19
Cervoni v. Secretary of HEW, 581 F.2d 1010 (1st Cir. 1978)	13
Ellis v. Blum, 643 F.2d 68 at 78 (2nd Cir. 1981)	16, 17
Goldberg v. Kelly, 397 U.S. 254 (1970)	22
Hadley Memorial Hospital, Inc., d/b/a Hadley Regional Medical Center, et al. v. Schweiker, No. 80-1806, issued Sept. 13, 1980, ___ F.2d ___, CCH Medicare and Medicaid Guide, §32,153 (10th Cir. 1982)	24
In Re Heath, 144 U.S. 92, (1892)	17
Joint Anti-Facist Refugee Committee v. McGraf, 341 U.S. 123 (1950)	14
Kendall v. United States, 37 U.S. 524 (1838)	24
Mathews v. Eldridge, 424 U.S. 319 (1976)	17-22
Northlake Community Hospital v. United States of America, 654 F.2d 1234 (7th Cir. 1981)	17-21
O'Bannon v. Town Court Nursing Center, 447 U.S. 773, Fn. 17 at 784 (1980)	18
Porto Rico Railway, Light & Power Company v. Mor, 253 U.S. 345 (1920)	15
Rockhill Care Center, Inc. v. Harris, 502 F.Supp. 1227, (W.D. Mo. 1980)	18, 19
Town Court Nursing Center v. Beal, 586 F.2d 266, (3rd Cir. 1978)	19, 20

United Mine Workers of America v. Gibbs, 383 U.S. 715, (1966) 23, 24

Weinberger v. Salfi, 422 U.S. 749 (1975) 23

Youngberg v. Romeo, ___ U.S. ___, 73 L.Ed.2d 28, 50 U.S.L.W. 9681 (U.S. June 1982) 13, 14

Statutes and Regulations Page

IC 12-1-7-14.9 et seq. (Ind. Legislative Council 1980 Cumm. Supp.) 3, 6

§916 Omnibus Reconciliation Act of 1980, P.L. 96-499 ..... 5, 11-16, 18, 24, 25

28 U.S.C. §1331 (1976 & Supp. 1982) 11, 22, 23

28 U.S.C. §1361 (1976 & Supp. 1982) 11, 16

42 U.S.C. §405(g) (1976 & Supp. 1982) 2, 17, 22, 23

42 U.S.C. §405(h) (1976 & Supp. 1982) 2, 17, 23, 24

42 U.S.C. §1395 et seq. (1976 & Supp. 1982) 2

42 U.S.C. §1395d(1976) 3

42 U.S.C. §1395f(1976) 3

42 U.S.C. §1395cc(b) (1976 & Supp. 1982) 2, 6

42 U.S.C. §1395ii 24

42 U.S.C. §1396 *et seq.* 11

42 U.S.C. §1396a(i)(1976 & Supp. 1982) 2, 4, 24

42 U.S.C. §1396i(c)(1976 & Supp. 1982) 2, 5

42 U.S.C. §1396cc(f)(1976 & Supp. 1982) 2, 6

42 C.F.R. §405.1101 et seq. (1975) 3

42 C.F.R. §405.1121(k)(1982) 14

42 C.F.R. §405.1510-1521(1982) 6

42 C.F.R. §§405.1551 et seq. (1982) 6

42 C.F.R. §405.1561 et seq. (1982) 6
42 C.F.R. §405.1567(1982) 6
42 C.F.R. §405.1902(a)(1980) 6
42 C.F.R. §405.1903(1980) 5
42 C.F.R. §405.1907(1980) 6
42 C.F.R. §431.10(1980) 3
42 C.F.R. §431.53(b)(1979) 6
42 C.F.R. §431.610(P)(1)(1980) 4
42 C.F.R. §442.12(1980) 4, 5
42 C.F.R. §442.15(1982) 4
42 C.F.R. §442.16(1982) 4
42 C.F.R. §442.20(b)(1980) 5
42 C.F.R. §442.100(1982) 3
42 C.F.R. §442.300 et seq. (1978) 3
42 C.F.R. §489.10(1980) 3
42 C.F.R. §489.11(1980) 4
42 C.F.R. §489.15(a)(1982) 4
42 C.F.R. §489.15(b)(1980) 4
42 C.F.R. §489.15(c)(d)(1980) 4
42 C.F.R. §489.53(1980) 5, 6

Other Authorities

S.Rep.No. 404 (Part I) 89th Cong. 1st Sess. (1965) reprinted in U.S. Code Cong. & Admin. News, 89th Cong. 1st Sess. 1943 20
H.R. Rep. No. 213, 89th Cong. 1st Sess. (1965) 20

H.R. Conf. Rep. No. 96-1479, 96th Cong., 2d Sess. (1980) Reprinted in U.S. Code Cong. & Admin. News 95th Cong., 2d Sess. 9963 15

R. Dickerson, The Fundamentals of Legal Drafting (1965) 15

Robert M. Gibson, "National Health Expenditures 1979", Health Care Financing Review, Vol. 2, No. 1, Summer 1980 19

THE OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit appears in Appendix A herein, *infra*, at p. A-1, and is reported at 668 F.2d 1062 (7th Cir. 1982). The Providers Petition for Rehearing and Suggestion for Rehearing En Banc was denied without written opinion. The Order denying Petition for Rehearing and/or Suggestion for Rehearing En Banc is included herein as Appendix C, at p. A-83.

The District Courts' Findings of Fact, Conclusions of Law and Entries of Judgment in the Care Inns, Inc. and Turtle Creek Convalescent Center, Inc. cases are not reported. They are reprinted in Appendix B, at pp A-74 and A-35, respectively. The Preliminary Injunction in the Americana Healthcare Corporation case is not published. It is reprinted in Appendix B, *infra*, at p. 32. The Restraining Order and Order for Hearing, Agreed Entry of January 14, 1981 and the Entry of January 27, 1981 in the Laura Hathaway case were not published. They are reprinted in Appendix B, *infra*, at p. A-76.

JURISDICTION

The Judgment of the Court of Appeals was entered on August 18, 1982. Petitioners' Petition for Rehearing and/or Suggestion for Rehearing En Banc was denied on October 8, 1982. The jurisdiction of the United States Supreme Court is invoked pursuant to the provisions of 28 U.S.C. §1254(1)(1976).

CONSTITUTIONAL PROVISIONS INVOLVED

The constitutional provision involved is the Constitution of the United States—Amendment V:

> "No person shall be...deprived of life, liberty, or property, without due process of law...".

STATUTORY PROVISIONS INVOLVED

The statutory provisions of primary importance to this Petition are 42 U.S.C. §1395cc(f) (1976 & Supp. 1982), 42 U.S.C. §1396a(i) (1976 & Supp. 1982), 42 U.S.C. §1396i(c) (1976 & Supp. 1982), 42 U.S.C. §405(g) (1976 & Supp. 1981) and 42 U.S.C. §405(h) (1976 & Supp. 1981), all of which are reprinted in Appendix D, at pages A-84, A-86, A-88, and A-89, respectively.

STATEMENT OF THE CASE

A. Nature of the Case.

In each of these actions, consolidated for purposes of appeal, the respective Petitioners filed actions in District Courts seeking injunctive relief, and stay of administrative orders. Named as defendants were the Secretary of the Department of Health and Human Services (hereinafter the Secretary and/or HHS) and the Indiana Department of Public Welfare (hereinafter DPW). Each Petitioner owned or operated nursing care facilities and each requested the District Courts to enjoin the discontinuation of participation of Petitioners' facilities in the Medicare and/or Medicaid Programs until a hearing was provided. This relief was requested since the respondents' actions to terminate Medicare and/or Medicaid participation, if not halted, would have resulted in the involuntary relocation of Petitioners' patients to other nursing homes, thereby causing incalculable, and perhaps fatal, injury to both the patients and financial ruination to the Petitioners.

B. The Statutory and Regulatory Framework.

"Medicare" is the common name for Federal Health Insurance for the Aged and Disabled and is set forth in Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq. (1976 & Supp. 1982). Part A of this program provides hospital and skilled nursing facility benefits to older Americans. It is totally federally funded and is administered by the Secretary of Health and Human

Services, although the actual inspecting of Medicare-approved facilities is routinely conducted by designated state agencies by contract. In Indiana it is the Indiana State Board of Health which performs the inspections for HHS.

Medicaid, established in Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.* (1976 & Supp. 1982) is principally intended to provide medical insurance benefits to poor individuals. The costs of Medicaid are shared by federal and state governments. (In Indiana, the federal government pays roughly 53% and the State pays 47%). The administration of this program is conducted by a designated state agency, 42 C.F.R. §431.10 (1980), which in Indiana is the Department of Public Welfare (DPW). The operation of the Indiana Medicaid Program is statutorily governed by IC 12-1-7-14.9 *et seq.* (Ind. Legislative Council 1980 Cumm. Supp.).

Medicare and Medicaid share the feature that payment for care rendered to beneficiaries in the program is made directly to the health care provider. 42 U.S.C. §1395d (1976) and §1395f (1976). In order to be eligible to receive reimbursement for care provided to Medicare or Medicaid beneficiaries, a facility must be "certified" under the appropriate program. To be eligible for certification a facility must meet certain "conditions of participation", 42 C.F.R. §489.10 (1980); 42 C.F.R. §442.100 (1982), which describe minimum requirements with respect to nursing, management, physical design, dietary administration and therapeutic services. 42 C.F.R. §442.300 *et seq.* (1978); 42 C.F.R. §405.1101 *et seq.* (1975). If a facility wishes to be certified under either Medicare or Medicaid, an inspection is made by a designated state survey agency (in Indiana, a division of the Indiana State Board of Health (ISBH)). Under Medicare the results of this survey, are reported to HHS's Health Care Financing Administration (HCFA). 42 C.F.R. §405.1902(a) (1980).

Under Medicaid the state survey agency is responsible for making the decision as to whether a facility is eligible to be certified, 42 C.F.R. §431.610(e)(1) (1980), and reports this decision to the State Medicaid agency. The final step for participation under these programs is the execution of a provider agreement. Under Medicare this agreement is between the facility and HHS, 42 C.F.R. §489.11 (1980) and under Medicaid it is between the facility and the state Medicaid agency. 42 C.F.R. §442.12 (1980).

These programs include two levels of nursing care, designated as skilled and intermediate care, which are distinguished chiefly by the intensity of care provided. Skilled care is the more intensive, as measured by the average number of nursing hours per patient per day. In Indiana Medicare reimburses only skilled care, while Medicaid pays for both skilled and intermediate care. A facility may be certified as a skilled nursing facility (SNF), or an intermediate care facility (ICF) or, if so qualifying, may choose to have one portion SNF-certified and another portion ICF-certified. Since the certification requirements for an SNF under Medicare are identical to those for a SNF under Medicaid, certification under Medicare automatically establishes eligibility under Medicaid.

Provider agreements are technically of limited duration. Generally, the agreements with facilities that are in full compliance with conditions of participation are limited to twelve months under both programs, 42 C.F.R. §489.15(b) (1980); 42 C.F.R. §442.15(a) (1982). Certain conditions may give rise to temporary extensions of the agreement period. 42 C.F.R. §489.15(c) and (d) (1980); 42 C.F.R. §442.16 (1982).

In addition to conducting pre-certification inspections, the state survey agency is responsible for periodic inspections of participating facilities to insure continued compliance with conditions of participation.

In the Medicare Program, HCFA of HHS may terminate a provider agreement upon a finding that the facility no longer meets conditions of participation, or on several other bases specified at 42 C.F.R. §489.53 (1980).[2] Each condition of participation is divided into "standards", which are further subdivided into "elements". Compliance surveys are conducted by surveyors from the designated state agency, 42 C.F.R. §405.1903 (1980).

Under Medicaid the federal regulations do not set forth a "laundry list" of reasons for terminating a provider agreement. The bases for cancellation of participation are left to the state Medicaid agency, although it is required that the agency have "... adequate documentation showing good cause..." 42 C.F.R. §442.12(d) (1982).[3] Since it is charged with administering the agreement, typically the decision to terminate a provider agreement under Medicaid will come from the state Medicaid agency. However, the Secretary of HHS retains the power to "look behind" the findings and recommendations of the designated state agencies where the Secretary has reason to question their reliability. In such instances the Secretary may unilaterally terminate the Medicaid agreement. See 42 U.S.C. §1396i(c) (1981). Furthermore, the termination by the Secretary of HHS of a Medicare agreement will necessarily require the state agency to terminate any agreement with the same facility which covers Medicaid-SNF care. 42 C.F.R. §442.20(b) (1980).

In Indiana DPW is statutorily prohibited from using State funds under Medicaid to reimburse a provider where the federal portion of the payment has not, or will not, be

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[2]HHS has not amended this regulation subsequent to the passage of the Omnibus Reconciliation Act of 1980, P.L. 96-499, 42 U.S.C. §1395cc(f) (1981).

[3]See 42 U.S.C. §1396(a)(i) (1981) as to state agency requirements under the Omnibus Reconciliation Act of 1980, P.L. 96-499.

provided by federal authorities. IC 12-1-7-14.9(b) (Ind. Legislative Council 1980 Cum. Supp.). The survey process under Medicaid is essentially identical, both substantially and temporally, with that of Medicare.

Following surveys under Medicare or Medicaid, the surveyors prepare findings as to a facility's compliance with applicable regulations. If deficiencies in elements are found, the facility may respond to the survey agency with a "plan of correction" describing the efforts to be taken to cure deficiencies that are admitted. Even with deficiencies present, a plan of correction acceptable to the secretary or the state agency will allow continued Medicare or Medicaid participation, respectively, so long as the deficiencies do not immediately jeopardize safety of patients. 42 C.F.R. §§405.1907 (1980), 442.105 (1980). If, however, the secretary finds that a facility no longer substantially meets conditions of participation, a facility cannot continue to be certified. 1395cc(b) (1976 & Supp. 1982).

In the event that conditions of participation are found unmet, a Medicare facility is notified by HHS that an "initial determination" has been made to this effect.[4] If the facility objects, it may then request the Secretary to "reconsider" this "initial determination", 42 C.F.R. §405.1510—1521 (1982). The facility may then appeal the initial determination and request an administrative hearing. 42 C.F.R. §489.53(c) (1980), 42 C.F.R. §§405.1551, *et seq.*, (1982).[5] If the result of the administrative hearing is adverse, the facility may then appeal to an "Appeals Council". 42 C.F.R. §405.1561, *et seq.* (1982). The finding of

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[4]In the Medicaid context in Indiana, a similar notice is sent to the facility by DPW.

[5]Under Medicaid the hearing must be held before the effective date of termination or within 120 days thereafter. 42 C.F.R. §431.53(b) (1979). Again, however, the Secretary has not amended these regulations to conform with 42 U.S.C. §1395cc(f) (1976 & Supp. 1982).

the Appeals council becomes the Secretary's "final determination" and the provider may then seek judicial review. 42 C.F.R. §1567 (1982). There is no provision allowing the Secretary to cease making payment before the "final determination" in either the Statutes or the Regulations.

C. **Statement of the Facts.**

No. 81-C-929, *Care Inns, Inc.* operates a Medicare and Medicaid certified nursing facility in Clarksville, Indiana. In a letter dated July 22, 1981, the Secretary notified Care Inns that, based on a state survey conducted in May, 1981, its Medicare agreement with the HHS would not be renewed effective September 1, 1981. The Secretary stated that the survey showed the facility had deficiencies which "immediately jeopardize the health and safety of the patients". Care Inns disputed the survey and requested a resurvey and a pre-termination hearing, the latter of which was denied by the Secretary. A resurvey was conducted on August 10th and 11th, 1981, and the facility was found to be in compliance with all Medicare conditions of participation. On August 25, 1981, representatives of the facility and the Secretary met and the HHS was requested to reconsider its original decision based upon the facility being in compliance. Representatives of the Secretary, however, announced that they maintained their original decision and, furthermore, reconsideration of their decision would not be completed until after the effective date of non-renewal. On August 31, 1981, Care Inns filed an action in the Federal District Court seeking injunctive relief to prevent the Department and DPW from terminating the facility from Medicare and Medicaid prior to a hearing, noting that the survey agency had found the facility in compliance. The District Court conducted a bench trial on the merits consolidated with a preliminary injunction hearing and found that no emergency existed at the facility

which justified the Department's denial of renewal. The injunctive relief requested by Care Inns was granted.

No. 80-C-1267, *R.N. Nursing Home* is located in Teagarden, Indiana, and is certified as a Medicaid provider only. In a letter dated December 4, 1979, the R.N. Nursing Home (R.N.) was notified by DPW that it was to be decertified from Medicaid participation as a result of state survey. R.N. requested that DPW conduct a hearing prior to decertification. Upon agreement of the parties' attorneys, this hearing was postponed pending the outcome of a State licensure proceeding involving allegations of the same deficiencies. The licensure proceedings were completed on August 18, 1980 and the home was accorded full licensure. DPW took no action subsequent to the facility being accorded full licensure. On September 23, 1980 HHS notified DPW that federal matching funds for state Medicaid payments for R.N. would be deferred because R.N. was not in compliance with Medicaid regulations. On December 19, 1980, DPW notified R.N. that it was required to defer any payment to the facility because state law prohibited the disbursement of state funds without federal matching funds. R.N. then commenced its action seeking to enjoin HHS and DPW from discontinuing R.N.'s reimbursement for care given to Medicaid patients. Following a conference before the District Court, at which all parties were represented, an agreed Temporary Restraining Order was granted on December 31, 1980, and this Order was subsequently continued by agreement on January 14, 1981, and by court order on January 27, 1981.

No. 81-C-58, *Americana Healthcare Corporation* owns and operates two nursing facilities in Indiana which were the subject of this litigation. Both facilities were certified to participate in the Medicare and Medicaid Programs. On October 22, 1980, HHS sent a letter to the Americana

facility at Elkhart (Americana-Elkhart) stating a survey had been conducted at this facility by the Indiana State Board of Health in August of 1980 and that deficiencies had been identified which "seriously limit your capabilities to render adequate care and insure the health and safety of your patients." The letter stated that HHS would not renew its Medicare agreement with Americana-Elkhart which would expire on December 1, 1980. This facility disputed the survey and timely requested a reconsideration of the Secretary's decision and a pre-termination hearing. HHS denied the request for such a hearing. A resurvey of the facility was conducted by the same state agency and HHS subsequently reaffirmed its decision to deny renewal of the facility's agreement, but extended the effective date of non-renewal until January 31, 1981. Subsequently Americana-Elkhart was notified by DPW that as a result of the Secretary's decision, the facility's Medicaid agreement would also not be renewed.

The other Americana facility involved in this action is located in Indianapolis (Americana-Midtown). By letter dated October 24, 1980, HHS notified Americana-Midtown that as a result of a State survey conducted in August, 1980, its Medicare agreement with the HHS would not be renewed effective December 1, 1980, using language operatively identical to that received by Americana-Elkhart. Americana-Midtown disputed the survey and timely requested both reconsideration and a pre-termination hearing. The hearing was refused but another survey was conducted by the State agency and the facility was subsequently informed by HHS that its original decision would be reaffirmed but that the effective date of non-renewal for this facility would also be backed up to January 31, 1981.

On January 27, 1981, these facilities commenced an action in the Federal District Court seeking injunctive relief against the Secretary and DPW seeking to prohibit

these agencies from terminating the facilities' participation in the Medicare and Medicaid Programs without pre-termination hearings based upon both the Secretary's existing rules and the Omnibus Reconciliation Act of 1980, 42 U.S.C. §1395cc(f) (Supp. 1982). Following an evidentiary hearing before the District Court, a preliminary injunction was issued against the Secretary and DPW.

No. 81-C-172, *Turtle Creek Convalescent Centers, Inc.* operates a Medicare and Medicaid certified nursing facility in Indianapolis (Northside). In a letter dated January 22, 1981 HHS informed Northside that a state survey conducted in November of 1980 had indicated deficiencies at the facility which "seriously limit your capability to render adequate care and insure the health and safety of your patients." HHS stated that it would not renew the facility's Medicare agreement scheduled to end March 1, 1981. The facility disputed the survey and timely requested reconsideration of the Secretary's decision and a pre-termination hearing. The hearing request was denied. The State agency began a resurvey of the facility on February 9, 1981, but this was discontinued when the facility was informed that the surveyors were bound to review and base their recommendations on entries in patient records which predated the survey of November, 1980. Documentary deficiencies in the pre-November 1980 patient records had been a principal focus of criticism of the facility following the November survey and, by law, could not be corrected. HHS then reaffirmed its original decision and Northside was subsequently notified by DPW that, as a result of the HHS action, DPW, too, was bound to discontinue Northside's Medicaid participation. Prior to the effective date of the sanctions threatened by DPW and the HHS, Northside commenced an action in the Federal District Court seeking injunctive relief prohibiting the termination of the facility's participation in Medicare and

Medicaid without a pre-termination hearing again based upon regulations as well as the Omnibus Reconciliation Act. At the conclusion of a bench trial, the District Court entered a permanent injunction preventing the Secretary and DPW from decertifying Northside prior to according the facility a pre-termination hearing as the state clearly requires.

In each of the foregoing actions, with the exception of Hathaway, the defendants challenged the district courts' subject matter jurisdiction, and this was the sole question for appeal raised by the Secretary. The state defendant DPW appealed in Care Inns, Inc. only and challenged the District Court's exercise of pendent jurisdiction.

D. Basis for Federal Jurisdiction in District Court.

In each of these actions, the Petitioners alleged before the Federal District Courts jurisdiction pursuant to 28 U.S.C. §1331(1976 & Supp. 1982), 28 U.S.C. §1361 (1976 & Supp. 1982), 5 U.S.C. §701 (1976), and 42 U.S.C. Chapters XVIII (which incorporates by reference 42 U.S.C. §405 *et seq.*) and XIX.

ARGUMENT

1. District Courts Clearly Had Mandamus Jurisdiction Pursuant to 28 U.S.C. §1361 to Order Compliance by the Secretary of the Department of Health & Human Services with Certain Directives Contained in the Newly Enacted 42 U.S.C. §1395cc(f).

In the District Courts the Petitioners invoked subject matter jurisdiction pursuant to 28 U.S.C. §1361 (1976 & Supp. 1982), arguing that the Secretary had failed to comply with the clear directives of §916 of the Omnibus Reconciliation Act of 1980, P.L. 96-499, now codified at 42 U.S.C. §1395cc(f)(1976 & Supp. 1982) (hereinafter referred to as ORA). The applicable provisions of the Act are as follows:

"SEC. 916 (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under Title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

"(2) *The Secretary shall not make such a decision* with respect to a facility *until such facility has had a reasonable opportunity,* following the initial determination that it no longer substantially meets the provisions of section 1861(j), *to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.*" [Emphasis Added]

Petitioners argued that the ORA clearly required the Secretary to offer a meaningful hearing prior to making any final decision to impose any sanctions on a provider against whom deficiencies are alleged. Alternatively, the

Petitioners argued that, at a minimum, they were entitled to a hearing in circumstances where the health and safety of patients were not immediately jeopardized. Noting that every District Court presented with evidence had concluded that no emergency or immediate jeopardy whatsoever existed at their facilities, the Petitioners argued that under *Cervoni v. Secretary of H.E.W.*, 581 F.2d 1010 (1st Cir. 1978) they had a clear right to relief and that mandamus was the proper remedy to force the Secretary to comply with the clear dictates of the ORA.

The Seventh Circuit concluded in its opinion that there was no right to a hearing where immediate jeopardy existed and, citing this Court's recent decision in *Youngberg v. Romeo*, ___ U.S. ___, 73 L.Ed. 2d 28, 50 U.S.L.W. 9681 (1982), found that the question of the existence of immediate jeopardy was not a proper consideration for the District Courts but rather should be deferred to the expertise of the *licensing agency*. Opinion p. 34. Presuming that the Secretary had found the presence of immediate jeopardy in each of these cases, the Seventh Circuit concluded that the Petitioners had no clear right to a pre-termination hearing and that mandamus jurisdiction was inappropriate.

The blatant error in the Seventh Circuit's reasoning is that it abhors both the facts in these actions and the applicable law. Factually, that Court disregarded the findings of three District Court Judges who had concluded that no evidence was presented which substantiated the mere allegations of the Secretary. The Seventh Circuit also was apparently oblivious to the fact that the *licensing agency*, toward which it contended deference should be shown, was not the Secretary but was in fact the Indiana State Board of Health—officials who admitted that they had taken no action commensurate with a finding of "immediate jeopardy". The official of the Secretary's office in charge of facilities in Indiana himself testified he had elected to let the Petitioners' provider agreements "expire",

thereby allowing the Petitioners' patients to remain at the facilities for months. Had this truly been a situation of immediate jeopardy, the actions of the Secretary would have been inconsistent with the ORA, which clearly directs the Secretary to proceed to terminate a facility's participation and cease payments for future patients. Finally, with the exception of Care Inns, in none of these actions did the Secretary's notice to the Petitioners contain allegations of "immediate jeopardy".

Legally, the Seventh Circuit relied on incomplete principles of administrative law to reach its conclusion that the District Courts had somehow abused their discretion. While relying on the deference principle articulated in *Youngberg, supra*, the Court ignored the corrolary set forth in *Bell v. Woolfish*, 441 U.S. 520 at 528 (1979), in which it was stated that the deference principle is not applicable where there is "...substantial evidence in the record to indicate that the officials had exaggerated their response...". While recognizing the utilitarian value of deferring factual determinations to responsible administrative agencies, this Court has long recognized that such deference should be no bar to judicial intervention where agency action is patently arbitrary, capricious or without foundation. *Joint Anti-Facist Refugee Committee v. McGraf*, 341 U.S. 123 (1950).[6]

Thus, by second guessing the triers of fact the Seventh Circuit framed an unnecessary issue—whether hearings are required in situations of immediate jeopardy—and answered this issue in the negative. Nevertheless, the Petitioners submit that the ORA does in fact call for a

[6]It must be presumed that the District Courts were acutely sensitive to the allegations made by the defendants and that the injunctive relief, if granted, would allow the allegedly threatened patients to remain in Petitioners' facilities. Further, any patient has the right to leave a facility if the care rendered is believed inadequate. 42 C.F.R. §405.1121(k)(1982).

hearing regardless of whether immediate jeopardy is alleged by the Secretary. This interpretation is supported by the language of the Act on its face. The "decision" referred to in sub-part 2 can logically only refer to the Secretary's "determination" in sub-part 1. It is a standard rule of statutory construction that where several words in a statute ("where the Secretary determines") are followed by a general clause ("the Secretary shall not make a decision") which is as applicable as much to the first and other words as to the last, the natural construction of the language demands that the clause be read as applicable to all. *Porto Rico Railway, Light & Power Company v. Mor*, 253 U.S. 345 (1920); see also *Fundamentals of Legal Drafting, Dickerson*, (1965), p. 86.

Petitioners interpretation is also supported by the language of House Conference Report No. 96-1479, pp. 140, 141, reported in (1980) U.S. Code Congressional & Administrative News, 96th Congress, 2nd Session, 9963, 9991-2 wherein the conference committee, describing its intent with respect to the essentially identical duties imposed upon state agencies by §916(b)(2), codified at 42 U.S.C. §1396i(c) (Supp. 1982), stated:

> "Under the conference agreement it is intended that federal financial participation should be continued with respect to Medicaid patients of a facility decertified by the Secretary during such reasonable time as is required to effect the transfer of Medicaid patients from the facility. Further, the conferees note that it is not the intention of this provision to alter access to a full evidentiary hearing *before* decertification of a facility occurs, as provided under current law." (Emphasis added)

The Seventh Circuit's interpretation of the ORA, so clearly contrary to both the facial language and the legislative history, was apparently intended to avoid a result wherein the Secretary would be prevented from

removing patients from an unsafe environment by providers who would exploit appeal procedures to avoid termination from Medicare or Medicaid and, in so doing, would unnecessarily prolong the presence of patients in unsafe surroundings. While the Seventh Circuit's concern is understandable, it misapprehends the position of the Secretary, whose function is merely that of a fiscal agent. The Secretary's responsibility is strictly to ensure that federal monies are not expended on sub-standard facilities. Monitoring the compliance of facilities with Medicare or Medicaid conditions of participation is the function of state inspectors, who perform this task under contract with the Secretary. Federal inspectors rarely set foot inside health facilities and none did so in the present actions. Furthermore, the state *licensing* agency has the responsibility of removing patients from unsafe facilities and it is uncontroverted that no such action was taken against any of the Petitioners herein. Even when substandard conditions are found, the Secretary does not have any authority to remove patients other than those under one of these programs. Privately funded patients could remain. This fact was ignored by the Seventh Circuit but such fact establishes the true parameters of the Secretary's authority and duty. Therefore, the Seventh Circuit's strained statutory construction does not further any persuasive public policy. The ORA established a clear duty on the part of the Secretary, a clear right for the Petitioners, and mandamus jurisdiction pursuant to 28 U.S.C. §1361 (1976) was properly invoked by the District Courts. 42 U.S.C. §405(h) (1976 & Supp. 1981) does not preclude §1361 jurisdiction. As Judge Friendly held in *Ellis v. Blum*, 643 F.2d 68 at 78 (2nd Cir. 1981);

> "...we are satisfied that jurisdiction is provided by 28 U.S.C. §1361 .... An impressive array of cases in this and other circuits has established that §1361 jurisdiction will lie to review procedures employed in administering social security benefits... [Citations

> omitted] ... Even more significantly, this court has twice held since *Salfi* that §405(h) does not preclude mandamus jurisdiction to review the Secretary's procedures in disability cases ...".[7]

Clearly the opinion of the Seventh Circuit is erroneous in this regard.

2. The District Courts Properly Exercised Subject Matter Jurisdiction in These Actions Pursuant to 42 U.S.C. §405(g).

In addition to the statutory challenge discussed under Issue 1, Petitioners in each of these actions argued that the denial of a pre-termination hearing violated due process rights guaranteed under the Fifth Amendment to the Constitution of the United States. It was argued that this challenge presented a colorable constitutional claim, which under this Court's teachings in *Mathews v. Eldridge*, 424 U.S. 319 (1976), constituted an exception to the judicial preclusion aspects of 42 U.S.C. §405(h) (1976 & Supp. 1981), thus conferring subject matter jurisdiction on the district courts pursuant to 42 U.S.C. §405(g) (1976 & Supp. 1981).

The Seventh Circuit held that its own decision in *Northlake Community Hospital v. United States of America*, 654 F.2d 1234 (7th Cir. 1981) was controlling and that the factual position of the Petitioners was not significantly different from the plaintiff in *Northlake*.[8] In

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[7]Judge Friendly's opinion is in accord with this Court's holdings in *Kendall v. United States*, 37 U.S. 524 (1838) and *In Re Heath*, 144 U.S. 92 (1892), wherein the Court held that a new statute which refers to another statute adopts the referred statute as it existed at the time of the new statute's adoption. Section 205 of the Social Security Act (now codified as 42 U.S.C. §405) precludes action under Section 24 of the Judicial Code of the United States. That Code did not encompass mandamus jurisdiction. 42 U.S.C. §405(h), although nominally excluding §1361 jurisdiction, is merely a compilation and has not been passed as positive law.

[8]*Northlake* was decided before the ORA became effective and ORA was not in issue. Furthermore, *Northlake* concerned a hospital not a nursing home, and the ORA applies only to nursing homes—totally distinguishing the applicability of that case.

the *Northlake* case it was held that the due process claim made by the terminated provider was not a colorable constitutional claim. In *Northlake* the Seventh Circuit explored, for *Eldridge* purposes, the private interest affected and the public interest at stake and found these weighing against the plaintiff. In its Opinion in the present actions, the Court's attention was primarily addressed to the *Eldridge* due process analytical factor of risk of error in the procedures preceding deprivation. Specifically, the Court noted that each of the Petitioners were afforded advance notice of the decision to decertify their facilities, that each was informed of the deficiencies upon which the decertification was based, that each was afforded an opportunity for a resurvey to demonstrate corrections, that each was permitted to submit documentation explaining or refuting the deficiencies, and that in the case of Care Inns, Inc. the facility was permitted to meet with employees of the Secretary and submit evidence of compliance prior to the effective date of termination.[9]

There has been no dispositive statement by this Court on a provider's constitutional right to a hearing prior to termination from federal financial participation. The question was indirectly mentioned but not resolved in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, Fn. 17 at 784 (1980).

In each of the District Courts, the Petitioners vigorously applied *Eldridge* due process analysis to the facts at hand; the granting of the relief sought by the Petitioners indicates the persuasiveness of these arguments. In brief, it was argued that the private interest to be considered was the termination of Petitioners' provider status under federal financial participation.[10] In both *Northlake* and

[9]It is again noted that such a procedure does not comply with the requirements of the ORA and the Secretary has refused to implement regulations to comply with this Act.

[10]While there is a technical difference between termination during the term of a provider agreement (decertification) and termination of the end of an agreement (non-renewal) for due process purposes the effect is the same in either action. See *Rockhill Care Center, Inc. v. Harris*, 502 F. Supp. 1227, (W.D. Mo. 1980); *Braceo v. Lackner*, 462 F. Supp. 436 (D. Cal. 1978).

Town Court Nursing Center v. Beal, 586 F.2d 266 (3rd Cir. 1978) this interest was dismissed as less weighty than that of the disability claimant in *Eldridge*. However, continued provider participation has been recognized as a constitutionally recognized property interest, *Hathaway v. Mathews*, 546 F.2d 266 at 230, (7th Cir. 1976), *Case v. Weinberger*, 523 F.2d 602 (2nd Cir. 1975). It was demonstrated to the District Courts in the present actions that continued participation was not simply a convenient revenue generating source; it was absolutely necessary to the Petitioner's continued existence as business entities. For similar findings, see *Rockhill Care Center, Inc., supra; Bracco, supra.*[11] Given the public notice which occurs when a provider is terminated, it is unreasonable to expect that new patients would seek admission, thereby compensating for the loss of Medicaid or Medicare beneficiaries. In addition, unlike the claimant in *Eldridge*, a nursing facility which eventually prevails in the Secretary's administrative channels would not receive retroactive reimbursement for funds wrongfully denied because those patients would have been removed. Furthermore, it is noteworthy that there are absolutely no time limits imposed upon the Secretary for conducting hearings or issuing findings during the administrative appeal of the termination action. In fact, in Care Inns the Regional Director of the Secretary stated that the informal reconsideration of Care Inns would not be completed until after termination. Finally, there is no statutory or regulatory authority for the Secretary's practice of terminating payments and removing patients prior to issuing a final decision. This unauthorized practice points out the need for pretermination hearings. The practice of stopping payments based on "initial

[11] In 1979 the care for over fifty per cent of the average nursing home's patients was paid for by federal financial participation. *Gibson, Robert M., "National Health Expenditures 1979" Health Care Financing Review*, Vol. 2, No. 1, Summer 1980, Government Printing Office.

determination" is unsupported by law and is contrary to the obvious intent of Congress that such an action be taken only after a final decision.[12]

Petitioners argued that the second *Eldridge* review factor, the Government's interest in expeditious deprivation of the private interest, clearly weighed in their favor. The Government's interest was articulated in *Northlake* as being protection of patient safety and in *Town Court* as minimizing undue expenses in administering the Medicare Program. As we noted in Issue 1 above, the patient safety question is a "red herring" since the state licensing agency, not employees of the Secretary, has the day to day responsibility for insuring patient safety and removing all patients (not only Medicare and/or Medicaid patients) from threatening environments. The rationale in *Town Court*, finding this factor in favor of the government, is also wanting since HHS failed to introduce any evidence before that court (or any of the District Courts in these actions) supporting the Secretary's contention that it would be any more expensive to hold a pre-termination hearing as opposed to a post-termination hearing. Certainly, whether or not pre-termination hearings would consitute an onerous administrative burden is not a proper subject for judicial notice, which the Third Circuit appears to have taken in *Town Court*. Since the Secretary's own delays in these cases ranged from 105 to over 400 days, certainly pretermination hearings could easily have been held prior to the effective dates of termination.

The final *Eldridge* factor is the risk of error in the deprivation of benefits. In both *Northlake* and *Town Court* the procedures leading to the termination of benefits were found, as in *Eldridge*, to be carefully structured and narrowly focused. This is not the case in nursing facility termination actions.

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[12]See S.Rep.No. 404 (Part I), 89th Cong. 1st Sess. (1965) *reprinted in* U.S. Code Cong. & Admin. News, 89th Cong. 1st Sess. 1943 and H.R. Rep. No. 213, 89th Cong. 1st Sess. (1965).

Rather than *Eldridge's* simple observation and diagnosis by physicians, the decision to terminate a provider's participation under Medicare or Medicaid is predicated upon reviews of a facility by surveyors with widely differing backgrounds and expertise, utilizing forms prepared by the Secretary which are replete with questions calling for non-quantifiable answers. The importance of the questions on these forms vary widely in their practical significance to patient health and no systematic method is employed to weight these questions in accordance with their significance to patient safety. Additionally, the evidence presented below demonstrated that considerable discretion is allowed to the surveyor in placing an alleged deficiency under one or more conditions of participation. See findings in Appendix B at p. A-69. Individuals who collect the data are state employees but the decision to terminate a provider is made by the Secretary's employees who merely review summaries. In short, as noted in *Rockhill, supra*, the procedures leading to the decision to terminate a provider are significantly more affected by subjective decision making than the narrowly focused medical decision in *Eldridge*. In the present actions, the most graphic examples of a provider's inability to reverse termination actions already in motion occurred in Northside and Care Inns. After Northside received notice of a proposed termination action, it immediately requested a resurvey in order to prove compliance with applicable regulations. Midway through the resurvey the facility was notified that the surveyors were obligated to note deficiencies in patient care documentation which predated the facility's correctional efforts and in fact had been a principal factor in the original termination decision. By law, the facility could not modify this documentation. The resurvey was stopped when the facility realized that, regardless of its correction of deficiencies, the results of the second survey would be as damaging as those in the first. In Care Inns the resurvey was completed and the facility was

found to be in compliance with Medicare conditions of participation. Nevertheless the Secretary arbitrarily persisted in his decision to terminate. When facility representatives presented additional information to the Secretary during the course of the administrative review phase known as "reconsideration", they were notified that the Secretary's reconsideration decision would for some unspecified and obviously arbitrary reason not be forthcoming until an unknown date after termination. Furthermore, in its hearing before the District Court, Care Inns first learned that employees of the Secretary had, prior to making the termination decision, prepared an in-house memorandum setting forth the rationale for their decision, which contained highly negative statements about events at the facility over the past ten years. This memorandum contained no reference to the fact that Care Inns had been operating the facility only for the past two years. The memorandum had never been supplied to the facility so that it could be rebutted.

In view of the highly subjective nature of the provider evaluation process, there is a substantial risk of deprivation and a pretermination hearing is called for in accordance with the principles set forth by this Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970). An analysis of these procedures in light of *Eldridge* clearly supports the Petitioners' claim that they have at least raised a colorable constitutional claim sufficient to allow the District Courts to exercise subject matter jurisdiction over the action pursuant to *Eldridge*, and 42 U.S.C. §405(g).

3. The District Courts Properly Exercised Subject Matter Jurisdictions in These Actions Pursuant to 28 U.S.C. §1331.

In each of these actions the Petitioners named as defendants not only the Secretary but also DPW, the state Medicaid agency. The relief granted by the District Courts

also enjoined DPW from discontinuing each of the Petitioners from Medicaid without a pre-termination hearing. Petitioners' theory against DPW involved the same federal constitutional and statutory challenges as against the Secretary but, in addition, it was argued that Indiana law independently required a hearing prior to termination from participation in the Medicaid Program. In Care Inns, only, DPW appealed the District Court's exercise of pendent jurisdiction.

The Seventh Circuit found that federal question jurisdiction pursuant to 28 U.S.C. §1331 (1976 & Supp. 1981) did not lie in these actions, and in support of this proposition again cited its own decision in *Northlake*, which itself was predicated on this Court's decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975). The Seventh Circuit held that *Salfi* established the principle that 42 U.S.C. §405(h) precluded the use of §1331 as a jurisdictional basis for challenging provider termination decisions. Having found §1361 mandamus jurisdiction inappropriate, and subject matter jurisdiction similarly unavailable under §1331 or 42 U.S.C. §405(g), the Court concluded that the District Court in Care Inns had abused its discretion by exercising pendent jurisdiction over the state defendants, citing *United Mine Workers of America v. Gibbs*, 383 U.S. 715 (1966).

The Seventh Circuit's holding is in conflict with *Town Court Nursing Center, Inc. v. Beal*, 586 F.2d 266 (3rd Cir. 1978) wherein it was held that the jurisdictional bar of 42 U.S.C. §405(h) did not preclude the exercise of subject matter jurisdiction pursuant to §1331 in an action in which an *independent violation* of due process rights is alleged against a state defendant. As noted above, all Petitioners herein stated claims against DPW premised upon DPW's violations of due process rights to which the Petitioners were entitled under the federal constitution, and also under

federal statutory law.[13] Each of the Petitioners were participants in Medicaid, and this Court has made no statement on whether constitutional and statutory challenges under Medicaid are foreclosed by 42 U.S.C. §405(h). In addition to the Third Circuit in *Town Court*, other circuits have found that §405(h) does not bar federal question jurisdiction for claims arising pursuant to 42 U.S.C. §§1396 *et seq.* See *Hadley Memorial Hospital, Inc. d/b/as Hadley Regional Medical Center, et al. v. Schweiker*, No. 80-1806, issued September 13, 1982, ___ F.2d ___, CCH Medicare and Medicaid Guide ¶32,153 (10th Cir. 1982). Furthermore, there is no provision in the Medicaid Act, 42 U.S.C. §§1396 *et seq.*, which carries the §405(h) jurisdictional limitations into that Act, in contrast to 42 U.S.C. §1395ii, which explicitly carries §405(h) into the Medicare Act. See *Califano v. Sanders*, 430 U.S. 99 (1976).

The Seventh Circuit failed to address petitioners' claims against DPW in its Opinion, thereby leaving the Petitioners to speculate on the validity of their claims against DPW. The Seventh Circuit's reliance on *United Mine Workers* is misplaced, since that case dealt with the presence of independent federal and non-federal claims. In the present actions, claims under federal law were articulated against both the Secretary and DPW. Petitioners' allegation that Indiana law also required a pre-termination hearing merely supplemented the federal claims against DPW. Thus, the Seventh Circuit's blanket dismissal of the Petitioner's actions against both the state

[13]The Court's attention is invited to §916(b)(1)(a), of the Omnibus Reconciliation Act of 1980 now codified at 42 U.S.C. §1396 a(i)(1981), which imposes upon state Medicaid agencies the same duties as are imposed upon the Secretary by 42 U.S.C. §1395cc(f), discussed under Question 1 of this Petition, *supra*.

and federal defendants is premature, and the District Court in Care Inns was correct in concluding that it could properly exercise pendent jurisdiction over DPW.

CONCLUSION

For these reasons, a Writ of Certiorari should issue to review judgment and opinion of the United States Court of Appeals for the Seventh Circuit, to clarify the rights and duties under §916 of the Omnibus Reconciliation Act of 1980 and to settle the conflicts among the several Circuit Courts of Appeal with regard to subject matter jurisdiction.

Respectfully Submitted,

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